Virginia ADAP
Virginia Department of Health
James Madison Building, 1st Floor
109 Governor Street
Richmond, VA 23219
PHONE: (855) 362-0658 FAX: (804) 864-8050

Hepatitis C (HCV)/HIV Treatment Assistance
APPLICATION

The information on this form will be used in determining eligibility for the Virginia AIDS Drug Assistance Program's (ADAP) HCV/HIV Treatment Assistance. A limited number of treatment slots are available (dependent upon available funding) for uninsured clients or whose insurance does not cover needed HCV medications. All questions must be completed, required documents much be attached, and the form must be signed by the client's medical provider applying for this assistance. Please Fax this form and required documents for immediate consideration.

Part A – Provider Information (To be completed by provider)			
Last Name:	First Name:		MI:
Practice/Hospital/Clinic Name:	Street Address (cannot accept P.O. Box):		
Controlled Substance Registration (CSR) Contact:			
Billing Tax ID#			
City:	State:	Zip:	
Telephone Number: ( ) _____ - _____	Fax Number: ( ) _____ - _____		

Part B – Patient Information				
Last Name:		First Name:		MI:
Address:		City:	State:	Zip:
Telephone Number: Home: ( ) _____ - _____ Cell: ( ) _____ - _____	Date of Birth:	Social Security Number:	Currently Enrolled in ADAP? _____ Yes _____ No *** ADAP enrollment must be completed before application can be approved**	
HCV Genotype(s):	Medication requested: ___ **Harvoni** ___ **Viekira Pak** ___ **Sovaldi** ___ **Daklinza** ___ **Epclusa** ___ **Zepatier** ___ **Ribavirin**			

Client Name: _____

Preferred Medication Access Site:

___ Provider site OR

___ Local Health Department (if yes, list Health Department) _____

Please attach the following (**required**):

- Recent HCV viral load lab result (within last 6 months) of >10,000 copies/ml
- Undetectable HIV viral load lab result (twice during 24 weeks prior to application) of <50 copies/ml
- HCV Genotype lab result
- HBV serologies (HBV surface antibody/surface antigen and HBV core antibody)

Please answer the following (answering "No" may not necessarily exclude client from assistance, unless indicated):

- Has client been on stable ARV regimen for at least 6 months? _____ Yes _____ No
- In your opinion, is client strongly adherent to current medical care? _____ Yes _____ No
- Has client been drug free for at least 3 months? _____ Yes _____ No (If No, please indicate use and frequency: _____)
- If female, is client pregnant? _____ Yes _____ No _____ N/A (If Yes, client is excluded at this time)
- Does client have decompensated cirrhosis? _____ Yes _____ No (If Yes, client is excluded at this time)
- Does the client have compensated cirrhosis? _____ Yes _____ No
- Does the client have significant fibrosis with cirrhosis? _____ Yes _____ No

Please answer the following:

- Has client had previous treatment for Hepatitis C? _____ Yes _____ No
  If yes, indicate medication(s) prescribed: _____

Please list ARV regimen prescribed:

_____
_____
_____
_____

Please list any other medications client is taking:

_____
_____
_____
_____

Part C – Patient Insurance Information

Is client insured?
_____ No (If No, skip rest of "Part C" of this form)
_____ Yes (If Yes, please provide the following information)

Name of Insurance Company:	Policyholder Name:
Copy of Denial Letter from insurance company for medication attached? (**required**) ___ Yes ___ No	Copy (front and back) of insurance card attached? (**required**) _____ Yes _____ No

Client Name: _____

PROVIDER AGREEMENT - READ CAREFULLY BEFORE SIGNING

- *I understand that services for ADAP HCV/HIV Treatment Assistance are dependent upon available funds.*

  - *I understand that by participating in ADAP HCV/HIV Treatment Assistance, I agree to the following terms:*
  - *Medical visits:*
    - *Up to 6 medical visits (1 initial visit and 5 follow up visits) will be reimbursed at all-inclusive fee-for-service rates "99205" (initial) and "99204" (follow up) of the HCS "Policy On Fee-for-Service Reimbursement For Outpatient Ambulatory HIV Medical Care" (located at: http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS/). Payment for all additional medical visits will be managed by the Provider and Client.*
    - *If I am associated with a current contract or Memorandum of Agreement (MOA) with the Virginia Department of Health's HIV Care Services (HCS) program, I can submit medical visit reimbursement requests in accordance with the HCS "Policy On Fee-for-Service Reimbursement For Outpatient Ambulatory HIV Medical Care" and terms of the agreement. Agreements will be modified to provide for reimbursements.*
    - *If I am not associated with a current contract or MOA with the Virginia Department of Health's HCS program, I can submit a request for reimbursement for each visit directly to HCS through the procedure explained to me by an HCS representative. I understand that:*
      - *I must submit a Commonwealth of Virginia's Electronic Data Interchange (EDI) Payment Agreement for Vendors form to receive electronic payment (provided to you by the HCS representative)*
      - *I must submit a W-9 (provided to you by the HCS representative)*
      - *Payments will be issued within 30 days of receipt of correct reimbursement information*
  - *Labs*
    - *The following labs will be paid by ADAP*
      - *HCV Viral load [HCV RT-PCR, quant.] (up to 7)*
      - *CBC [CBC, platelet, no differential] (up to 7)*
      - *CMP [Comprehensive metabolic panel (12)] (up to 10)*
      - *INR (1)*
      - *HBV Serology (HBV surface antibody/surface antigen and HBV core antibody)*
    - *If I am associated with a current contract or MOA with the Virginia Department of Health's HCS program, labs will be provided through the existing terms of the agreement (modified to provide for reimbursements)*
    - *If I am not associated with a current contract or MOA with the Virginia Department of Health's HCS program, I will refer approved clients to a LabCorp site, using lab forms provided to me.*
  - *Audit*
    - *I understand that the Virginia Department of Health may request documentation that services were provided as paid for through this program up to 5 years after provision of these services.*
  - *I understand I will establish a Controlled Substance Registration through the Division of Pharmacy Services to have the medications shipped to my site.*
  - *I understand I will submit a prescription with refills to cover the course of treatment if this application is approved. The prescription will be filled for 30-days at a time, and the medication will be shipped to my office to distribute to the client.*
  - *Prescriptions received from VDH Pharmacy Services will be stored in a secure area, defined as a lockable area with access restricted to licensed staff.*
  - *A log of each transaction will be maintained that includes: Name of the patient on the prescription; Date received; Signature of Staff person that received the medication; name of the medication and quantity received; date picked up by the patient or their representative; signature of the patient or their representative that picked up the medication. If picked up by someone other than the patient or a person whose identity is not known to the staff they should request to see a form of identification that verifies signature.*
- *I agree to distribute provided medications only to the client referenced in this application. I will notify ADAP if treatment is interrupted, and return any undistributed medications to Central Pharmacy.*
- *Information provided on this form is accurate to my knowledge, and I have attached the following required forms:*
  - *At least one (1) detectable HCV viral load lab result within the last six (6) months*
  - *Most recent HIV viral load **and** HCV Genotype lab results*
  - *Copy of Denial Letter for medication coverage from insurance company (for insured clients)*
  - *Copy of insurance card, front and back (for insured clients)*

Signature of Provider: _____ Date:_____